THE UNIVERSITY OF TENNESSEE
Health Science Center
877 Madison Avenue, 7th Floor
Memphis, TN 38163
901.448.2920

THE MID-SOUTH TELEHEALTH CONSORTIUM

July 1, 2002

The Commissioner of the FCC
236 Massachusetts Avenue, NE, Suite 110
Washington, DC 20002

Dear Commissioner,

In response to the FCC NPRM Docket No 02-60 regarding the Universal Service mechanism for healthcare, the University of Tennessee Health Science Center and the Mid-South Telehealth Consortium would like to submit the following recommendations for consideration:

1. The mechanism fosters a perverse disincentive for many telecommunication companies to invest in new infrastructure that may bring newer and more affordable services to rural areas. The FCC's February 15, 2002 NPRM on the Rural Health Care Support Mechanism reiterates that "common carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account." Allowing a telecommunications company the opportunity to charge their "highest tariffed" rate while using existing facilities means there is no incentive to add new infrastructure or services which may be more affordable in rural areas.

2. This mechanism can also encourage telecommunication providers to raise the rates they charge to customers. For instance, in one western state a carrier who was charging a client $600 a month for T1 services under a discounted arrangement simply increased the cost to $1,200 a month (highest tariff) because they knew the client would still pay the same under the discount mechanism. This is an indication of how one telecommunications provider legally raised rates while exploiting the support mechanism for an additional $600 per month. We don't believe Congress intended for such behavior to occur.

3. Since communication expenses are the most expensive component of many Telehealth program, most have negotiated special discounted rates with their

THE UNIVERSITY OF TENNESSEE
Health Science Center
877 Madison Avenue, 7th Floor
Memphis, TN 38163
901.448.2920

THE MID-SOUTH TELEHEALTH CONSORTIUM

July 1, 2002

The Commissioner of the FCC
236 Massachusetts Avenue, NE, Suite 110
Washington, DC 20002

Dear Commissioner,

In response to the FCC NPRM Docket No 02-60 regarding the Universal Service mechanism for healthcare, the University of Tennessee Health Science Center and the Mid-South Telehealth Consortium would like to submit the following recommendations for consideration:

1. The mechanism fosters a perverse disincentive for many telecommunication companies to invest in new infrastructure that may bring newer and more affordable services to rural areas. The FCC's February 15, 2002 NPRM on the Rural Health Care Support Mechanism reiterates that "common carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account." Allowing a telecommunications company the opportunity to charge their "highest tariffed" rate while using existing facilities means there is no incentive to add new infrastructure or services which may be more affordable in rural areas.

2. This mechanism can also encourage telecommunication providers to raise the rates they charge to customers. For instance, in one western state a carrier who was charging a client $600 a month for T1 services under a discounted arrangement simply increased the cost to $1,200 a month (highest tariff) because they knew the client would still pay the same under the discount mechanism. This is an indication of how one telecommunications provider legally raised rates while exploiting the support mechanism for an additional $600 per month. We don't believe Congress intended for such behavior to occur.

3. Since communication expenses are the most expensive component of many Telehealth program, most have negotiated special discounted rates with their

communications carriers. Over the past decade, the Federal government has invested hundreds of millions of dollars in telehealth programs and demonstration projects. The inability to sustain this investment, attributable to unaffordable telecommunication costs, defeats the well intentioned efforts of Congress and those seeking to enhance access to necessary healthcare services, as may be needed for purposes of national security and/or rural preparedness.

4. The mechanism does not specify the time in which a telecommunications company must respond to the completion of the Rural Health Care Division's (RHCD) forms and this creates huge budget and cash flow problems for those receiving the discounts. Those problems are:

    a. The eligible provider must pay the full cost of the eligible service and receive a rebate only after all of the telecommunication company forms have been completed. To help clarify this issue, we will use the same western state example mention above. At one point, the customer in this western state was paying $600 per month for their telecommunication service without the USF discounts. Thinking it would not impact the customer, this customer's telecommunications provider raised their rate to the highest tariffed rate of $1,200 per month. While this level of thinking might be true in the long run, the upfront costs for this telehealth program doubled. It is also common for eight months of elapse between the time of the initial application and the receipt of the Universal Service discount. In this example, each site could have paid an additional $4,800 before this discount was received. Most small healthcare providers cannot afford such financial outlays.

    b. Due to delays in the administration of the mechanism and in a telecommunication company's response to completing the necessary RHCD forms, rebates may not appear in the same fiscal year as the expense. This creates major accounting problems for individual whose yearly funding comes from federal grant sources, and for others who must also develop accurate fiscal year budgets.

    Our recommendations to deal with this issue include the following:

    1. Telecommunication companies would have a maximum of 90 days to complete and finalize all the forms with the RHCD.

    2. During that 90-day period, the telecommunication carrier may bill the customer for all applicable charges.

    3. After that 90-day period, the telecommunication carrier may only bill the customer for the discounted amount and must rebate the difference for the

first 90 days of service, within 45 days of completion for the RHCD forms.

4. If the telecommunications carrier fails to respond in 90 days, they must continue the telecommunications service and refrain from billing the customer until such time the forms have been finalized.

While the above process may seem extreme, it may be the only way to get the telecommunication provider to deal with the mechanism in a timely manner, without creating budget and major cash flow problems for the customer.

Recommendations:

- We would like the Commission to consider the expansion of the definition of eligible health care provider to include any rural, not-for profit health care entity with a certified Medicare and/or Medicaid provider number. Expanding the definition as suggested would mean the Universal Service support mechanism will be more widely used and meet its potential.

- For purposes of simplicity, we respectfully ask the Commission to define rural areas as any area not designated as a metropolitan statistical area (MSA) and include any area falling under the Goldsmith Modification within an MSA.

- The Commission should also consider amending the eligible provider list to include for-profit hospitals.

  In many rural communities, a for-profit entity may be the ONLY provider of healthcare services. Absent discounted telecommunications services, rural citizens in that community would not have access to the benefits of telehealth, as per the intent of Congress, if the cost of establishing connectivity to telemedicine networks is prohibitive, as is often the case.

- The ONLY hospital in a rural county; an/or

- That hospital or health care provider provides services to Medicare and Medicaid patients at a level of more than 50% of their gross revenues accrued in services to the these patients. It could be argued that these hospitals are public in character by virtue of the beneficiaries they serve.

Recommendations:

- We suggest that prorating services are unnecessary if the telecommunications network is private and dedicated, the telehealth program stipulates that the telehealth interactive video activities occur on the network, the program maintains records to that effect, does not resell

time, and does not connect the network to voice switching equipment that would attach to the public phone network.

- If the network is public or semi-private, then proration needs to be governed by the following principals and grouped into the proration table provided below.

a. Proration of network time that is **not** resold must occur on a per event basis and not on a time basis. This means that one dermatology event that takes 6 minutes counts the same as one educational event that takes 1 hour. As another example, if 250 dermatology encounters, 250 psychiatry encounters and 50 regional boy scout meetings occur in one year the percentage of time in non-health care activities would be 9% (50/550) and according to the table below would not trigger any proration of the service.

   We recognize that in the above case the Commission will be very concerned with potential fraud and abuse issues related to those telehealth networks that pay per-minute charges for network connections. Recognizing this concern, we would simply state that given the current financial status of rural, not-for-profit hospitals, it would be unlikely that any hospital would allow any other not-for-profit or for-profit organization to use their network for free. These hospitals could not afford to pay the per-minute charges for another organization. Thus, these services would be resold and fall into "b" below.

b. Any amount obtained by the applicant through reselling the telecommunications portion of a video connection, regardless of the table below, must be refunded to USAC within 45 days of the end of the USAC funding year.

c. The burden of record keeping for all health and non-health related events and the reselling of services shall be placed on the rural site receiving Universal Service support, even if the applicant of record filed as a consortium or on behalf of the rural site.

d. Any difference due to USAC as a result of any other type of prorating activities must be refunded to USAC within 45 days of the end of the USAC funding year.

e. Upon random audit by USAC, auditors will request records detailing utilization of network events.

Internet Access

In general:

We concur that discounts should be provided to support any form of Internet access provided to rural health care provider as long as the cost to provide such services in rural areas exceeds the same level of service in any urban area of the State.

We concur that discounts should be provided to underwrite access to internet connectivity via any modality, to include "non-telecommunications service providers". In some communities, other providers of telecommunications technology such as the local cable operator or public utility board have chosen to invest in infrastructure so as to provide broadband access to the Internet. We believe that healthcare providers who choose to access those services should be eligible for discounts if that telecommunications technology provides quality of service that support its use for medical purposes.

Sincerely,

Karen Fox

Karen Fox
Assistant Dean, College of Medicine